STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	000105	A. BUILDING: _____ B. WING _____	C 09/17/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARQUETTE	8140 TOWNSHIP LINE RD INDIANAPOLIS, IN 46260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 000	INITIAL COMMENTS This visit was for the Investigation of Complaint IN00152983. Complaint IN00152983 Substantiated. No deficiencies related to the allegations are cited. Survey Dates: September 16 & 17, 2014 Facility number: 000105 Provider number: 155198 AIM number: NA Survey Team: Mary Jane G. Fischer RN TC Census bed type: SNF: 78 Residential: 59 Total: 137 Census Payor type: Medicare: 23 Other: 114 Total: 137 Sample: 3 Marquette was found to be in compliance with 410 IAC 16.2 in regard to the Investigation of Complaint Number IN00152983. Quality Review 09/17/14 by Lisa McColly	R 000		